AMBULANCE AUTHORIZATION FORM FOR MEDICAID

Beneficiary's Name_____ **Medicaid I.D. Number:** _____

I certify that it is medically necessary for this patient to be transported by ambulance. Transportation by any other means could be detrimental and medically inadvisable. This certification is provided within my professional scope of practice and applicable state law. I further certify this transport is not a transport of convenience; advanced planning or scheduling of transportation is not an option; and that this patient is unable to ambulate without assistance.

Level of ambulance transport required:

_____ Ambulance Service, Basic Life Support, Non-Emergency Transport (BLS) – (Procedure Code A0428)

(A DHEC licensed ambulance company vehicle with staff and equipment on board that provides treatment in basic life support situations.)

I understand that Medicaid will only cover transport to Medicaid-sponsored services in accordance with the following age limitations. This recipient is being transported to and from the following Medicaid service:

From	**To**
___R-Residence	____P-Physician Office
___H-Hospital	____H-Hospital
___N-Nursing Home	____N-Nursing Home
___P-Physician Office	____G-Hospital-Based Dialysis
___G-Hospital-Based Dialysis	____J-Non-Hospital-Based Dialysis*
___J-Non-Hospital-Based Dialysis*	____076 (Duplicate procedure, same day of service)
___Adult Residential Facility	____Emergency Vision Care (to age 21)
___Unlisted/Other-----**Provide complete address and telephone number below:**	____Preventive and Restorative Dental Care (to age 21)
	____Emergency Dental Care (over age 21)
	____Adult Day Health Care*

_____
_____
_____
_____

***(Requestor must prior authorize unplanned/unscheduled service and specify existing medical condition below.)**

Specify Existing Medical Condition: _____
_____
_____
_____

_____ (Requestor, Title) Date: _____/_____/_____
(Attending physician, physician assistant, nurse practitioner, clinical nurse specialist or registered nurse)

_____ (Facility Name) County: _____

Vehicle odometer reading (To): _____

Vehicle odometer reading (From): _____

DHHS Form 216